

Ridgecrest Summer Camps Health Form

Complete and Return to:



**THIS FORM MUST BE COMPLETED AND RETURNED
AT LEAST 2 WEEKS PRIOR TO YOUR SESSION**

- Page 1 and Sections 1 & 2 to be completed by parent.
- Sections 3 & 4 to be completed by Licensed Medical Personnel.
- Exception: Section 2 Immunization Record may be completed by Parent or Physician's Office.

Cabin: _____

Session: _____

Year: _____

OFFICE USE ONLY

Attending Session: **1A** (6/7-6/19) **1B** (6/21-7/3) **2A** (7/5-7/17) **2B** (7/19-7/31) **Starter** (8/2-8/7)

Social Security # _____ Sex _____ Height _____ Weight _____

Name: _____ Age _____ Birth M/D/Y _____ Years at Camp: _____

Parent or Guardian: _____ Phone: (____) _____

Home Address: _____
Street Number City State Zip Code

Sibling(s) Attending Ridgecrest/Crestridge: _____

Mother's Occupation: _____ Work Phone: (____) _____ H Phone: (____) _____
 Cell Phone: (____) _____

Father's Occupation: _____ Work Phone: (____) _____ H Phone: (____) _____
 Cell Phone: (____) _____

In An Emergency, Please Notify: _____ Relationship: _____ Phone: (____) _____

If **NOT** Available in Emergency, Notify: _____ Relationship: _____ Phone: (____) _____

Name of the Family Physician and/or Health Care Clinic: _____ Phone: (____) _____

Name of Ophthalmologist/Optomertist: _____ Phone: (____) _____

Date of Last Physical Examination: _____ Name of Physician: _____ Phone: (____) _____

Do you carry family medical/hospital insurance? If so, indicate carrier: _____ Policy/Group No. _____

***** PHOTOCOPY OF FRONT AND BACK OF HEALTH INSURANCE CARD AND PRESCRIPTION CARD MUST BE ATTACHED TO THIS FORM.**
 INSURANCE: ACCIDENT INSURANCE is included in the camp fee up to a set limit. Any doctor or druggist bills incurred as a result of **illness** will be mailed directly to the parents.

Operations or serious injuries (dates): _____

Chronic or recurring illness or medical condition: _____

Current Prescription Medications: _____

Medical Diet Restrictions: _____

ALLERGIES:

- | | |
|--------------------------------|--------------------|
| _____ Asthma | _____ Foods: _____ |
| _____ Hay Fever | _____ |
| _____ Poison Ivy | _____ |
| _____ Insect Stings | _____ Drugs: _____ |
| _____ Severe (stops breathing) | _____ |
| _____ Mild (swollen/rash) | _____ |
| _____ Other (notes): _____ | _____ |

PARENT ITINERARY:

If you as a parent or guardian plan to be out of town while your child is at camp, please indicate your complete itinerary below and numbers where you can be reached:

| Date | Place | Phone # | |
|------|-------|---------|--|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

IMPORTANT- MUST BE COMPLETED FOR ATTENDANCE

To my knowledge, this health history is correct and complete. The person herein described has permission to engage in all camp activities except as noted. I give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I also give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This form may be photocopied for trips out of camp.

Date: _____

Parent Signature _____

I agree to abide by the restrictions placed on my camp activities as noted on this health form.

Date: _____

Camper or Staff Signature _____

Name: _____

Complete Page 1 and Sections 1 & 2 BEFORE Seeing Physician: Include emergency information and restrictions / special care that should be observed. Record any injuries, illness, surgery, or significant changes in condition of applicant since last complete exam.

Section 1: Give dates and full details below for any "Yes" Answers.
IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):

| | Yes | No | Year | | Yes | No | Year |
|----------------------|-----|-----|------|---------------------------|-----|-----|------|
| 1. Serious Illness | ___ | ___ | ___ | 17. Eyes/Ears | ___ | ___ | ___ |
| 2. Serious Injury | ___ | ___ | ___ | 18. Hearing Imp. | ___ | ___ | ___ |
| 3. Deformity | ___ | ___ | ___ | 19. Hypertension | ___ | ___ | ___ |
| 4. Surgery | ___ | ___ | ___ | 20. Convulsions | ___ | ___ | ___ |
| 5. Skin / Glands | ___ | ___ | ___ | 21. Epilepsy | ___ | ___ | ___ |
| 6. Sinusitis | ___ | ___ | ___ | 22. Constipation | ___ | ___ | ___ |
| 7. Heart | ___ | ___ | ___ | 23. Athlete's Foot | ___ | ___ | ___ |
| -Murmur | ___ | ___ | ___ | 24. Panic Attacks | ___ | ___ | ___ |
| -Rheumatic Fever | ___ | ___ | ___ | 25. Bronchitis | ___ | ___ | ___ |
| 8. Chest / Lungs | ___ | ___ | ___ | 26. Fainting | ___ | ___ | ___ |
| 9. Stomach / bowels | ___ | ___ | ___ | 27. Depression | ___ | ___ | ___ |
| 10. Appendicitis | ___ | ___ | ___ | 28. Sore Throats | ___ | ___ | ___ |
| 11. Kidneys / Urine | ___ | ___ | ___ | 29. Bleeding/ Clotting | ___ | ___ | ___ |
| -Albumin | ___ | ___ | ___ | 30. Mono | ___ | ___ | ___ |
| -Sugar | ___ | ___ | ___ | 31. Sprain / break | ___ | ___ | ___ |
| -Infection | ___ | ___ | ___ | 32. Chicken Pox | ___ | ___ | ___ |
| -Bed-wetting | ___ | ___ | ___ | 33. Measles | ___ | ___ | ___ |
| 12. Menstrual Prob. | ___ | ___ | ___ | 34. Germ. Measles | ___ | ___ | ___ |
| 13. Hernia | ___ | ___ | ___ | 35. Mumps | ___ | ___ | ___ |
| 14. Back/limbs/joint | ___ | ___ | ___ | 36. Asthma | ___ | ___ | ___ |
| 15. Sleepwalking | ___ | ___ | ___ | 37. Tuberculosis | ___ | ___ | ___ |
| 16. Nervous Cond. | ___ | ___ | ___ | 38. Other: explain | ___ | ___ | ___ |

39. Are you aware of any current health problems? ___ Yes ___ No
 40. Now under medical care or taking medicine? ___ Yes ___ No
 41. Has there been any surgery, injury, illness, allergy, or change in health status since last physical exam? ___ Yes ___ No
 Details: (Give # & Details or attach separate sheet with info) _____

CONDITION OF EYES: Glasses ___ Contacts ___ NA ___
 What procedures should be taken if broken at camp? _____

CONDITION OF TEETH: Braces ___ Retainer ___ NA ___
 What procedures should be taken if broken at camp? _____

For Girls: Has she Menstruated? ___ If not, has she been informed? ___
 If so, is her menstrual history normal? _____

IMPORTANT: URGENT, FOR THE WELL-BEING OF ENTIRE CAMP, YOU MUST notify the camp if camper is exposed to any communicable disease during the three weeks prior to camp.

Section 2: IMMUNIZATION HISTORY

To be completed by Parent or Physician's Office

Required immunizations must be determined locally. Please record the date of basic immunizations and most recent boost doses.

| Vaccination | Year of Basic Immunization | Date of Recent Booster |
|-------------------------------|----------------------------|------------------------|
| DTP | _____ | _____ |
| TD (tetanus/diphtheria) | _____ | _____ |
| Tetanus | _____ | _____ |
| Polio | _____ | _____ |
| MMR | _____ | _____ |
| Or Measles | _____ | _____ |
| Or Mumps | _____ | _____ |
| Or Rubella | _____ | _____ |
| Haemophilus influenza B (HIB) | _____ | _____ |
| Hepatitis B | _____ | _____ |
| Varicella (chicken pox) | _____ | _____ |
| TB Mantoux Test | Date of last test _____ | Pos. ___ Neg. ___ |

THIS PORTION TO BE FILLED OUT BY LICENSED MEDICAL PERSONNEL

Section 3: HEALTH EXAM

ATTENTION EXAMINER: To attend Ridgecrest Camps, a health examination within the past 12 months is required. The applicant will be participating in an active and strenuous activity schedule including one or more of the following: athletic participation / competition, horseback riding, water sports, gymnastics, dance, archery, riflery, ropes course, climbing tower, tennis, walking / hiking over rocky terrain, overnight camping and other general camp activities.
 --Please insist applicant furnish complete medical history before exam.
 --Please review immunizations for applicant to insure appropriate immunizations are current. Tetanus booster within last 10 years is required (unless there is a national shortage and booster is unavailable).
 --After completing Section 3, summarize any restrictions and/or recommendations in Section 4, below, **AND ATTACH ANY ADDITIONAL INFORMATION.**

Height ___ Weight ___ Blood Pressure ___ / ___ Pulse ___

Hearing: ___ Normal ___ Abnormal

Vision: ___ Normal ___ Glasses ___ Contacts ___

Check box if normal, circle if abnormal, and give details below:

- | | |
|--|---|
| <input type="checkbox"/> Growth development | <input type="checkbox"/> Skin, glands, hair |
| <input type="checkbox"/> Head, neck, thyroid | <input type="checkbox"/> Ears |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Nose |
| <input type="checkbox"/> Teeth, tonsils | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Abdomen, hernia |
| <input type="checkbox"/> Skeletomuscular | <input type="checkbox"/> Neuropsychiatric |
| <input type="checkbox"/> Other (specify) _____ | |
| <input type="checkbox"/> Comments _____ | |

Participant is under the care of a physician for following conditions:

Condition Current Medication To be continued at camp
 Specify dose or treatment

- Any condition that may require special care, medication, or diet:
 ___ Asthma ___ Convulsions / Epilepsy ___ Heart Trouble ___ Contacts
 ___ Diabetes ___ Fainting ___ Dentures ___ Bleeding Disorders
 ___ Concussion / Loss of Consciousness ___ ADD / ADHD

Circle Allergies to: drugs, foods, plants, animals, insects, chemicals
 Specify: _____
 Indicate treatment: _____

Explain or **ATTACH** additional information _____

Section 4: EXAMINER'S EVALUATION AND ADVICE:

Date Examined: _____
 I have examined camp applicant within the past year. In my opinion the applicant's condition ___ does ___ does not permit participation in an active camp program.
 Specific restrictions/Recommendations: (explain other limitations or restrictions) _____

ADDITIONAL INFORMATION IS ATTACHED

Licensed Examiner's Signature: _____

Address: _____

Phone: _____

Date of Form Completion _____ *By _____
 *Initial if completed by nurse or nurse practitioner

Ridgecrest Summer Camps Phone: 1-800-968-1630

FAX: 828-669-5512

PAGE 2